NAME: _____

KENTUCKY J-1 VISA WAIVER PROGRAM PLACEMENT VERIFICATION FORM

Please Check One: Kentucky State 30 J-1 Visa Waiver____ ARC J-1 Visa Waiver____

Physician Name: _____

INS J-1Visa Waiver Approval Date: _____ H-1 (b) Approval Date: _____

Initial Employment Start Date (After the Approval of the J-1 Visa Waiver): _____

Home Address:
Street: _____
City: _____State: _____ Zip Code: _____

Home Phone: _____

Name and Address of Primary Work Site:
Name: _____
Street: _____
City: _____ State: _____ Zip Code: _____
County: _____ HPSA: _____
Phone: _____ Fax: _____

Additional Worksites:
_____
_____

_____ _____
Physician's Name Date

_____ _____
Owner/CEO Name Date

Return this form to:

John W. Hensley
Health Program Administrator
Health Care Access Branch
Division of Child and Adult Health
275 East Main Street, HS2GW-A
Frankfort, Kentucky 40621